

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/30/2008
NAME OF PROVIDER OR SUPPLIER WARD			STREET ADDRESS, CITY, STATE, ZIP CODE 806 FLORAL PL, NW WASHINGTON, DC 20012		
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I 000	INITIAL COMMENTS A licensure survey was conducted from May 29, 2008 through May 30, 2008. A random sample of two residents was selected from a resident population of three males with various disabilities. The findings of the survey were based on observations, interviews with two residents, staffs, program coordinators in the home, as well as a review of resident records, administrative records, and incident reports.	I 000			
I 060	3502.18 MEAL SERVICE / DINING AREAS Perishable foods shall be stored at proper temperatures in order to conserve nutritive value. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that equipment necessary for monitoring deep freezer temperatures was provided. The finding includes: Observations during the environmental walk-thru on 5/30/08 at 8:43 AM revealed no thermometer located in the bottom part of the kitchen refrigerator. Interview with facility's House Manager acknowledged that there was no thermometer in bottom part of the kitchen refrigerator.	I 060	The facilities weekly check list will be revised to include thermometer in both refrigerator and freezer. Both QMRP and head counselors will monitor and use checklist to ensure placement. Please find enclosed copy of revised checklist.	2008 JUN 27 DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION -27-08	
I 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used.	I 091			

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Michael Warren

TITLE

Program Director

(X6) DATE

6-19-08

6899

BPM811

If continuation sheet 1 of 12

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I 091	Continued From page 1 This Statute is not met as evidenced by: Based on observations and interview, the facility failed to maintain the interior and exterior of the GHMRP in a safe, clean, orderly, attractive, and sanitary manner. The finding includes: Observation and interview with the House Manager during the environmental walk through on 5/30/08 beginning at 8:43 AM revealed the following: Interior 1. The hand rails leading from the front entrance door to the kitchen was observed to be loose. 2. Torn plastic covering was observed in the window located in the laundry room. 3. A large hole in the wall was observed at the bottom of the basement steps. Exterior 1. There was paint chipping observed on the front entry door. Bedrooms Knobs were missing on the top and second drawers in Resident # 2's bedroom.	I 091	Interior: 1. Hand rails leading from front entrance to kitchen have been tightened. 2. Laundry room window covering has been replaced. 3. the Hole in the wall at the bottom of basement steps has been repaired. Exterior: 1. Front door entry has been repainted. Bedroom: Knobs have been replaced. Additionally head Councilor will weekly complete checklist and QMRP will provide weekly oversight.	6-30-08 6-30-08 6-30-08
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach	I 095		

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I 095	Continued From page 2 of each resident. This Statute is not met as evidenced by: Based on observation and interview revealed that the GHMRP failed to ensure that caustic agents were stored in a locked cabinet. The finding includes: During the environmental walk-thru on 5/30/08, "dish washing detergent" caustic agents were observed stored under the kitchen sink.	I 095	The facilities checklist has been revised to include proper storage of all caustic agents. This checklist will be completed weekly by lead councilor and QMRP will provide oversight.	6-30-08	
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the House Manager and review of the staffing pattern on 5/29/08 at approximately 9:26 AM revealed the scheduled shifts are as follows: Weekdays 1st Shift 8 AM to 4 PM 2nd Shift 4 PM to 12 PM 3rd Shift 12 AM to 8 AM Weekends/Saturday and Sunday	I 135			

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I 135	Continued From page 3 1st Shift 8 AM to 4 PM 2nd Shift 4 PM to 12 PM 3rd Shift 12 AM to 8 AM Further interview with the House Manager revealed that the staff was required to conduct a drill once per month on each shift. Review of the fire drill log book from May 2007 to May 2008 revealed that the facility failed to hold simulated fire drills at least four times a year for each shift during. There was no evidence that fire drills were conducted quarterly on all shifts.	I 135	Review of fire drill record indicate that there were 4 fire drills performed during 5/07-5/08 on each shift 8-4: 7/20/07, 4/19/08, 5/11/08, 5/25/08. 4-12: 7/12/07, 7/24/07, 7/26/07, 7/14/08. 12-8: 7/4/07, 9/10/07, 4/22/08, 7/5/08. Please find copies attached.	6-20-08
I 165	3507.4(c) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (c) Health and safety, which covers fire safety and evacuation, infection control, medication, and procedures for emergency and the death of a resident; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure a policy on health and safety to include trauma and death. The findings include: 1. Interview and review of the GHMRP's policies and procedures manual on May 29, 2008 revealed the GHMRP failed to have a policy to include funeral/burial. 2. Interview with the facility's Registered Nurse and review of the GHMRP's policies and procedures manual on May 29, 2008 revealed the GHMRP failed to have a policy on destroying	I 165	#1. Please find attached copy of Funeral and Burial policy. #2. Please find attached copy of policy on destroying medications.	6-20-08 6-20-08

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I 165	Continued From page 4 medications.	I 165		
I 168	3507.4(f) POLICIES AND PROCEDURES 3507.4 The manual shall incorporate policies and procedures for at least the following: (f) Admission, transfer and discharge, which covers admission criteria: pre-and post-admission activities, program planning, transfer and discharge procedures; and... This Statute is not met as evidenced by: Based on record review, the facility failed to have a policy on record keeping. The finding includes: Review of the personnel policies and procedures on 5/29/08 at 9:49 AM revealed, the GHMRP failed to have a policy on admission, transfer, and discharge, which covers admission criteria: pre-and post-admission activities, program planning, transfer and discharge procedures at the time of the survey.	I 168	(P) Please find attached Policy on Admission, transfer, and dis- charge policy.	6-20-08
I 184	3508.5(a) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (a) All major components of the administering agency or the roles of individuals when the licensee is not an agency; This Statute is not met as evidenced by: Based on interview and review, the GHMRP failed to provide an organizational chart reflecting the changes in the components of the agency's	I 184		

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I 184	Continued From page 5 staffing structure. The finding includes: The finding includes: Review of the agency's policy and procedure manual failed to evidence an organization chart reflecting the changes in the components of the agency's staffing structure and lines of authority. Interview with the Lead Counselor and House Manager on May 29, 2008 at approximately 2:30 PM revealed that the current organization chart did not reflect the Qualified Mental Retardation Professional (QMRP) as an individual who was employed by the agency.	I 184	<i>Please find attached revised organizational chart.</i>	6-20-08	
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees. The findings include: Review of the personnel files conducted on 5/29/08 at approximately 3:12 PM, revealed the GHMRP failed to provide evidence of current signed job descriptions for three staffs at the time of the survey. (Staff #1, #2, and #3)	I 203			
I 204	3509.4 PERSONNEL POLICIES Each employee shall be given a copy of his or her job description to review and sign at the	I 204			

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I 204	Continued From page 6 beginning of employment. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all new employees. The findings include: Review of the personnel files on 5/29/08, the GHMRP failed to provide current job descriptions for two new employees who had been employed. (S#2 and #3).	I 204	QMRP will monitor staff folders quarterly to ensure all staff records are current. Please find attached copies of job descriptions for staff (#2, #3)	6-27-08
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff had current health certificates on file. The findings include: 1. Review of the personnel files conducted on 5/29/08, revealed the GHMRP failed to provide evidence of current health certificates for two staffs. (S #2 and S#3) 2. Review of the personnel files conducted on 5/29/08, revealed the GHMRP failed to provide	I 206	1. QMRP will monitor staff and consultant folders quarterly to ensure all records are current. Please find attached current health certificates. 2. See 1206 #1.	6-30-08 6-30-08

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I 206	Continued From page 7 evidence of current health certificates for two consultants at the time of the survey. (C#1 and C#2)	I 206			
I 225	3510.5(b) STAFF TRAINING Each training program shall include, but not be limited to, the following: (b) Human development through the life cycle (birth to death); This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure effective training was provide to each staff. The finding include: Review of the training records on 5/29/08 revealed that the GHMRP failed to provide training on Human Development.	I 225	GHMRP will provide staff in-service training on Human Development by 6-27-08.	6-27-08	
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in first Aid and CPR for employees. The findings include: On 5/29/08, review of personnel records/training records revealed that the following staff,	I 227	GHMRP will monitor staff consultant and nursing record quarterly to ensure all records are current. All records will be current by 7-11-08.	7-11-08	

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I 227	Continued From page 8 consultants and nurses, were without current First Aid and CPR, or both at the time of the survey. 1. Current CPR - S#1 2. First Aid - S #1, C#1, and C#2	I 227			
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on record review the facility failed to report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). The findings include: 1. The review of the facility's unusual incident reports and interview with the Lead Counselor/House Manager on May 29, 2008 at approximately 3:30 PM, revealed the facility failed to report the following incident(s) to the appropriate authorities: a. Review an a nurse's note dated 7/19/07 on	I 379			

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I 379	Continued From page 9 May 29, 2008 at approximately 12:56 PM revealed that Resident #2 was discharged from Greater Southeast Hospital due to psychotic behaviors. Interview with the facility's Registered Nurse on 5/30/08 revealed that Resident #2 was physically aggressive toward staffs. b. An unusual incident report, dated 12/11/07, revealed that Resident #1 was involved in a vehicle accident. Further of the incident report revealed that Resident #1 was transported to the emergency room for an evaluation.	I 379			
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of three residents in the sample. (Resident#1 and #2) The findings include: The facility's nursing services failed to ensure that Resident #1 and #2 Abnormal Involuntary Movement Scale (AIMS) was updated as evidence below: 1. Observations of the evening medication administration on 5/29/08 at 5:58 PM revealed Resident #1 was administered Oxcarbazepine 900 mg, Lithium Carbonate 900 mg, and	I 401			

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1401	<p>Continued From page 10</p> <p>Lorazepam 0.5 mg by mouth. Review of Resident #1 medial records on the same day at approximately 2:45 PM revealed no AIMS exam. Interview with the facility's RN revealed that the AIMS exams are usually conducted every six months. Further interview with the RN revealed that she was unable to locate Resident #1's AIMS exam in her working files. The RN stated that Resident #1 was transferred to a new psychiatrist and that she wanted the new psychiatrist to conduct the first AIMS exam on the Resident. The RN further stated that an AIMS exam should have been conducted prior to Resident #1 transferring to a new psychiatrist. At the time of the survey, there was no evidence that the RN had completed an updated AIMS exam for Resident #1.</p> <p>2. Observations of the evening medication administration on 5/29/08 at 6:04 PM revealed Resident #2 was administered Abilify 20 mg, Clonidine HCL 0.1 mg, Depakote 500 mg two tabs, and Haldol 5 mg by mouth. Review of Resident #2 medial records on 5/29/08 at approximately 12:59 PM revealed an AIMS exam dated 11/14/07. Interview with the facility's RN revealed that the AIMS exams are usually conducted every six months. Further interview with the RN revealed that Resident #2 was transferred to a new psychiatrist and that she wanted the new psychiatrist to conduct the first AIMS exam on the Resident. The RN stated that why Resident #2 did not have a recent AIMS exam. At the time of the survey, there was no evidence that the RN had completed an updated AIMS exam for Resident #2.</p> <p>Note: A faxed copy of Resident #2's AIMS exam dated 12/19/07 was forwarded to my office a day after the survey had been completed.</p>	1401	<p>AIMS ATTACHED FOR #1</p> <p>AIMS ATTACHED FOR #2 FAX'D</p>		

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